COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
DISCHARGE / TRANSFER FORM

SUBMIT DISCHARGE/TRANSFER FORM TO:
Website: http://publichealth.lacounty.gov/sapc/
Fax: (XXX) XXX-XXXX

1. Name (Last, First, and Middle)	2. Date of Birth (MM/DD/YY):	3. Medi-Cal Number:
4. Admission Date:	**5. Discharge Date:**	**6. Discharge Diagnosis:**

7. Narrative summary of the course of treatment episode:

8. Patient's Prognosis: ☐ Good ☐ Fair ☐ Poor

Please explain:

9. Description of relapse triggers and plan to avoid relapse when confronted with each trigger:

10. Medications (including dosage & response):

11. Reason for Discharge/Referral:

☐ **. Completed treatment goals/plan at this level of care (LOC) [option no available for WM; If Q94A-Yes, Q94 cannot =1; logic pattern]**

☐ **. Left before completing treatment goals/plan with satisfactory progress**

☐ **. Left before completing treatment goals/plan with unsatisfactory progress**

☐ **. Discharged by agency for cause (e.g., non-compliance with agency rules)**

☐ **. Incarceration [administrative discharge]**

☐ **. Death [administrative discharge]**

☐ **. Other**

- ☐ **7a. Designated SUD level of care (LOC) is not available at this site**
- ☐ **7b. Discharged into other, more appropriate system of care (e.g., mental health)**
- ☐ **7c. Does [administrative discharge]**
- ☐ **7d. Specify** _____

12. If the patient is being discharged from a residential treatment service,has the length of stay been less than or equal to seven (7) calendar day… ☐ **Yes** ☐ **No**

13. Recommendations for Follow Up:

14. Is a copy of this Discharge/Transfer Form provided to the patient?

☐ **Yes** ☐ **No** **Explain:**

15. Provider's Name:	15. Provider's Signature:	16. Date:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Patient Name: **Medi-Cal ID:**

Treatment Agency:

DISCHARGE / TRANSFER FORM INSTRUCTION

The discharge plan shall be completed within thirty (30) calendar days of the date of the last face-to-face treatment contact with the patient.

1. Enter the patient's name in the order of last name, first name, and middle name.
2. Enter the patient's date of birth.
3. Enter the patient's Medi-Cal identification number.
4. Enter the patient's admission date.
5. Enter the patient's discharge date.
6. Enter the patient's discharge diagnosis.
7. Enter a narrative summary of the treatment episode. Describe services received and the patient's response.
8. Mark the appropriate box for patient's prognosis: "Good", "Fair", or "Poor", and provide an explanation.
9. Enter a description of relapse triggers an plan to avoid relapse when confronted with each trigger.
10. Enter the patient's medications. Include dosage and response.
11. Enter the reason for the discharge/referral. If none of the listed reason is applicable, check "Other" and provide an explanation.
12. If the patient is being discharged from a residential treament service, check "yes" if the length of stay has been less than or equal to 7 clendar days; otherwise, check "no".
13. Enter any recommendations for follow up including specify referred level/type of care.
14. If a copy of this form is provided to the patient, check "Yes"; otherwise, check "No" and provide an explanation.
15. Print the provider's name.
16. Enter the provider's signature.
17. Enter the date the provider signs the form.

INTERNAL SAPC USE ONLY

This section reserved for internal SAPC use only.

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